Department of Industrial Accidents Technical Assistance Tool

Audit tool provides information to assist your Program to complete the Utilization Review and Quality Assessment Program Application 452 CMR 6.00 et seq. (Printed 8/2/05)

NAME: **ADDRESS:**	**UR AGENT #:** **FEIN #:**	**DATE OF INITIAL APPROVAL:** **LAST AUDIT:**	**DATE OF REVIEW:** **STATUS:**

I	**ORGANIZATIONAL DEMOGRAPHICS**	**YES**	**NO**	**INC**	**Regulatory Requirements**	**Reviewer Comments/Recommendations/Suggestions**
A. **B.** **C.**	**Corporate & Site Contact Information and Demographic** 1. Name of Applicant listed. 2. Name of Program or D.B.A listed. 3. Applicants Corporate, Mass. and Public contact listed. 4. Toll-free numbers included. *Organizations that conduct Massachusetts utilization review at multiple sites within the organization must seek separate approval for each site conducting such review.				It is important to note that all documents and information submitted by UR Agents and Applicants are subject to disclosure under the provision of the Public Records Statute MGL c. 6.0 et seq.	
	<u>Exhibit A</u> Has the applicant been approved to perform Utilization Review for Workers' compensation in other states? If yes list states.					
II	**Treatment Guidelines & Review Criteria** A. The applicant will use the Health Care Service Board (HCSB") endorsed Treatment Guidelines and the Department's Review Criteria for all conditions where they apply? B. Identify all secondary sources of treatment guideline(s)/review criteria to be used for medical conditions not covered by HCSB-endorsed Treatment Guidelines: 1. Secondary sources listed. 2. # 4 is checked for internally derived treatment guidelines.				For approval in Massachusetts all applicants must attest to compliance with the use of the HCSB Treatment Guidelines endorsed by the HCSB and adopted by the Commissioner pursuant to MCL c. 152, sections (13) & (30) for those conditions for which they apply. B (4) shall always be checked as there is always the potential for medical conditions to be identified which do not conform to any guideline (HCSB or secondary source) and therefore will require the creation of an internally derived treatment guideline.	

	Exhibit B **Describe how the applicant's internally derived treatment guideline(s) and review criteria are developed and revised, including:** 1. Application identifies the role of the medically qualified Practitioner(s) who is/are involved in the development of the internally derived treatment guideline(s) and review criteria; 2. Applicant adequately describes the format in which the internally derived treatment guideline(s) and review criteria shall be maintained. 3. Application includes the frequency with which the revisions will occur (at least annually). 4. Provide a detailed narrative description of the development process. Internally derived treatment guideline(s) are developed through the use of clinically based literature and scientific research. 5. If the program sub-contracts' any part of their internal guideline development process it must have policies and procedures in place that explain the procedure and verify that the program provides appropriate oversight of the sub-contractors. 6. Internally developed treatment guidelines and review criteria used to determine a utilization review request are provided to the ordering/treating provider, injured employee/representative when requested.				Internally derived treatment guidelines shall be used when there is a medical condition for which no other primary (HCSB) or secondary treatment guideline exists. The application should include a detailed description of the medically qualified individual(s) responsible for the development of the internally derived treatment guideline(s). Include the recommended format for internal guideline development is one similar to the HCSB treatment guideline and review criteria. The recommended frequency for review and/or revision of such guideline(s) is at least annual. All treatment guidelines in MA including internally derived treatment guidelines shall be based on conditions/diagnoses not treatment/services.	

	Exhibit C: **Describe how each of the secondary sources above will be applied to review the conditions of injured employees.**				The application should identify the UR agent's process for the use of all secondary source guidelines. In Massachusetts the UR agent is required to attest in the application submission that the HCSB treatment guidelines and review criteria will be utilized solely for those conditions for which they apply. If there is no applicable HCSB treatment guideline or review criteria that applies to the medical condition under review the agent should apply and cite the secondary source used to make the medical determination.	

III	REVIEW PROGRAM:	YES	NO	INC	Regulatory Requirements	Reviewer Comments/ Recommendations/Suggestions
	<u>Exhibit D:</u> Formerly exhibit F *(incorporate the departments' recommended clinical procedures relating to clinical review time frames for each type of review and collection of additional information. (These clinical review procedures are available on the Departments web site* www.state.us/dia *see the OHP link to the application).* **Attach a flow chart and a detailed narrative of the applicant's procedure for conducting prospective, concurrent, and retrospective Utilization Review from initial request through final appeal. Include the following:** 1. Application includes flow charts for prospective, concurrent, and retrospective review process that indicates the correct time frames for each step of the process. 2. Flow charts indicate which health care professionals conduct clinical reviews. 3. Flow charts correctly describe who is notified of the review determination, how they are notified, and outline appropriate time frame for responding. 4. Flow charts and narrative include description of the appeal process including both expedited and standard appeal reviews, and final complaint to the DIA 452 CMR 6.04 (5). 5. Flow charts and narrative clearly identify which level of staff is performing each of the various review functions. 6. Application narrative and flow charts indicate that administrative personnel are limited in function to the collection and transfer of demographic data and the screening processes that do not require clinical review or clinical judgement. 7. Flow charts and narrative for initial clinical review clearly differentiates initial clinical review process from appeal level school to school review process. 8. Flow charts clearly indicate time lines for each step of the clinical review process and appeal level review process that are in accordance with 452 CMR 6.00 et seq. 9. Narrative descriptions and flow charts include description of procedures that cover data collection and information requests for review. 10. Policy and procedure includes a statement that information is accepted from any reliable source that will assist in the approval process, and those review determinations are made solely on the medical information available at the time of the review. 11. Narrative should include a description of the availability, with timelines, of health care professionals who provide clinical reviews, and to discuss determinations with ordering providers. 12. Program has a policy and procedure in place that addresses the failure or inability of an ordering provider or injured worker or their representative to provide the necessary information to make an appropriate review determination. 13. Application indicates that in Massachusetts minimum level of licensure for a clinical review is RN. However, LPN may conduct UR if the applicant provides an appropriate description of the supervision and oversight of the LPN by the RN.				The application narrative should cite or accurately paraphrase the provisions of 452 CMR 6.00 et seq. for approval. Terminology must be consistent throughout the application when referencing reviewers. Flow charts should indicate time frames in which review determinations for the various review processes are expected to be completed in accordance with 452 CMR 6.00 et seq. The utilization review process refers to specific services such as physical therapy, inpatient hospitalization, chiropractic, etc. Since 452 CMR 6.00 et seq. refers to all health care services, applications shall incorporate the utilization review process to be inclusive of all health care services. All individuals conducting clinical reviews shall be licensed health care professionals with prior clinical experience, and who are qualified to render a clinical determination about the health care service(s) under review, and who hold a current, unrestricted license to practice in a state in the United States.	

	Exhibit E: **Describe the process for written notification of adverse determinations to the ordering provider and injured employee:** A. Program has a policy that states that written notification of all adverse determinations shall be provided to the injured employee/representative, and the ordering practitioner. B. Program application indicates that all written notification of Adverse Determination contain the following: 1. Review of HCSB Treatment Guidelines or secondary sources. 2. Clinical Rationale for Adverse Determination 3. Procedure to initiate appeal process. 4. Identifier and school of reviewer.				In Massachusetts all guidelines and clinical rationale used in making an adverse determination for a specific case under review must be specific to the case under review, and disclosed in writing to the employee, employee representative, and ordering provider/practitioner.	
	Exhibit F: **Provide a detailed description of the standard and expedited appeal procedures by which a practitioner or injured employee may seek review of the applicant's utilization review determination.** 1. Application policies and procedures clearly states that the Program will maintain and make available a written description of the appeal procedure by which an ordering practitioner and/or injured employee may seek review of a determination by the UR Agent. 2. Expedited appeal procedure: when an adverse determination not to approve a health care service is made prior to, or during an ongoing service requiring review, and the injured employee and/or provider believes that the determination warrants immediate appeal, the injured employee and/or the provider shall have an opportunity to appeal that determination over the telephone to the UR agent, with the right to speak to a practitioner of the same school on an expedited basis. The appeal must occur not later than 30 days from the date of receipt of notice of adverse determination. Program policies shall include the completion of the adjudication on an expedited basis, within two business days of the date the appeal is made 452 CMR 6:04 (4), c, 1. 3. The Department's expedited appeal procedure is included and incorporated into the application. 4. Standard Appeal - UR agents shall complete the adjudication of all other appeals of adverse determination no later than twenty days from the date the appeal is filed. 5. Include flow charts for both standard and expedited reviews. Flow charts and appeal procedures include time frames for each step of the review process. 6. The flow charts and narrative for the appeal level review should include timeframes for making and issuing a written determination. Also, list how and who receives notification of the determination. 7. Procedure for appeal clearly indicates that a clinical reviewer other than the one who made the original decision must conduct appeal considerations.				Expedited appeal needs to be completed for Prospective and Concurrent Review. Standard appeal for Retrospective only. 6:04 (5) After exhaustion of the process set forth in 452 CMR 6:04 (4)(c) appealing the determination of the UR Agent, or if payment of an approved claim or complaint in accordance with 452 CMR 1.07 under the provisions of M.G.L. 152 sections (8)(4) and/or (10) use complaint for 110 or 115 on DIA website at www.state.us/dia Include reference to DIA website and forms 110 and 115 in narrative description of appeal process: www.state.us/dia	

	Exhibit G I: **Describe the applicant's internal quality assessment monitoring process, and how it will evaluate and measure the quality of its program. This description should also include, but not be limited to, reviewer decisions and the education and training requirements for each category of reviewer.** **1.** Include the following: 1. Outline of formal training program for each level of clinical reviewer that includes specific review of Massachusetts's regulation 452 CMR 6.00 et seq. and the principles and procedures of utilization management. 2. Copy of organizational flow chart for Utilization Management Department indicating reporting/supervisory relationships. 3. Copies of orientation/training content outline for non-licensed employees. 4. Policies that clearly indicate that all levels of clinical reviewers hold a current unrestricted license in a state in the United States. 5. Policies indicate all school–to-school reviewers are licensed in the same licensure category as the ordering provider and who selects the assigned reviewer. 6. Table of medical subspecialties of clinical reviewers. 7. Corporate organizational chart that includes quality management plan, membership of quality management committee, and the composition of the quality management department. 8. Include policies and procedures describing the monitoring and oversight; and evaluation and organizational improvement of clinical review activities. 9. Policies and procedures require that all clinical reviewers be in active practice at 8 hours per week in accordance with 452 CMR 6.00 et seq. 10. Include complaint and grievance procedure that informs all injured workers and/or their representative of their right to file a complaint with the Department of Industrial Accidents; if their concerns cannot be resolved by the Agent's internal grievance procedures. 11. Policies and procedures describe a quality management program that monitors and evaluates it utilization management review process and provides intervention as needed to support compliance with 452 CMR 6.00 et seq. 12. Application clearly states that clinical reviewers will not conduct case management of the same case they are providing utilization review. 13. Description and function of the QA committee that oversees all UR activities, including the role, structure and function of the committee. Minutes and reports of all QA meetings should be kept on file in the UR Agent's office. 14. QI committee meeting and reports that include the review and evaluation of the result of quality improvement activities, corrective actions and follow-up taken related to deficiencies.				The Code of Massachusetts Regulation, 452 CMR 6.07, requires that the Department of Industrial Accidents monitor the utilization review techniques used, and the determinations made, by utilization review agents. The department receives and investigates complaints from providers, employers, and employees regarding the conduct of UR agents believed to be in violation of 452 CMR 6.0 et seq., the worker's compensation utilization review and quality assessment regulations. Form 133A is filed to complain about the action or inaction of a UR agent.	

	G ll Health Services Contracting 1. The UR organization has written procedures describing their contracts with individual practitioners and organizational providers, including those making UR decisions, and specify that contractors cooperate with the UR organizations quality improvement program. 2. The UR organization provides sample contracts with licensed clinical review staff that specifically require: • The licensed clinical review staff cooperates with QI activities and follows mandates of 452 CMR 6.0. • The UR organization has access to the licensed clinical review staff medical records to the extent permitted by state and federal law. • The UR organization safeguards the security and privacy of injured employees and guarantees that UR records will not be accessed for the purpose of case management or any other non-workers compensation function within the organization. 3. The UR organization has written procedures that describe its network in numbers and types of clinical review staff who conduct utilization review functions. 4. The UR organization has written procedures to ensure availability of clinical reviewers to complete timely clinical reviews in accordance with 452 CMR 6.0 5. The UR organization has written procedures for analyzing and measuring the performance of clinical reviewers.					

	Exhibit G lll A. The UR organization provides sample copies of the organization's materials that will be sent to providers, employees, and others to inform them of the UR organization and its services (including but not limited to letters, notices, brochures, etc.) or all services, including utilization review. B. If the UR organization provides additional services, other than utilization review such as but not limited to i) vocational rehabilitation services; ii) independent medical examinations performed pursuant to M.G.L. c. 152 section 45; iii) unique services such as patient advocacy; iv) case management services (including medical case management), the applicant must demonstrate in its written procedures how those services which are approved by the Department as part of its UR program is ***delineated*** from those other services. C. Will the applicant provide any economic incentive(s) to achieve cost savings in its program? The UR organization has written procedures that indicate that no contract between a licensed clinical reviewer may contain any incentive plan that includes a specific payment to a practitioner as inducement to reduce, delay, or limit specific, medically necessary services. D. The applicant must agree that clinical reviewers will not conduct case management of the same case(s) they are providing utilization review. Explain how Utilization Review records are separated and kept confidential from all other ancillary programs.					
IV	**UTILIZATION REVIEW NOTIFICATIONS, DETERMINATIONS, AND APPEAL PROCEDURES:**	**YES**	**NO**	**INC**	**Regulatory Requirements**	**Reviewer Comments/Recommendations/ Suggestions**
	Exhibit H: **The UR organization provides clearly marked sample copies of letters, which the applicant will use to conduct its business as a Utilization Review Agent pursuant to 452 CMR 6.0 et seq. Include the following:** 1. UR organization has written procedure that indicates it issues a letter of introduction that includes introductory paragraph to injured employee, information regarding the ID card sent by the insurer and who to contact (& telephone number) if the card has not been received, information regarding a emergency care, and that the UR agent shall allow 24 hours after emergency admission, service, or procedure for an injured employee or their representative to request approval of such service, and a paragraph that outlines the utilization review agent complaint process that addresses complaints against the actions or in-actions of UR Agents and. 2. UR organization has a written procedure that indicates it issues an approved determination letter including introductory paragraph and guidelines used to approve service. 3. UR organization has a written approved appeal letter including introductory paragraph and guideline reviewed, and explanation of school to school review which indicates review done by different reviewer than initial adverse determination, and includes identifier and school of reviewer. 4. The UR program has a written adverse determination letter that includes introductory paragraph; guideline, clinical rationale, identifier and school of reviewer and appeal/complaint process. 5. The UR program has a written adverse determination letter upholding an initial adverse determination that includes introductory paragraph guideline, clinical rationale, and appeal/complaint process and explanation of school to school review which indicates review done by different reviewer than initial adverse determination, and includes identifier and school of reviewer. 6. The UR program has a written request for information letter that includes a description of the additional information required, the date of the request, and language that allows the ordering practitioner 7 business days to return the information.				All letters should include an introductory paragraph reflecting the regulatory statute. Effective July 1, 1993, all workers' compensation insurers are required to undertake utilization review of injured workers' health care services. The Utilization Review and Quality Assessment Program, 452 CMR 6.00 et seq. applies to all claims irrespective of date of injury, for health care services rendered on or after October 1, 1993. All letter stationary should include 1-800#. Letters should be cc: to injured employee or provider and on the UR agent's Letter Head. 6:07 (4) The Department shall monitor the utilization review techniques used, and determinations made by the utilization review agents. If the Commissioner receives a complaint from a practitioner, employer, or employee, or has reason to believe that a utilization review agent has been or is engaged in conduct that violates these regulations, the Commissioner shall notify the utilization review agent in writing of the alleged violation. The utilization review agent shall have 30 days from the date the notice is received to respond to the alleged violation and request a hearing. Upon receipt of said request, the Commissioner, or his designee, shall schedule a hearing. The hearing shall be conducted pursuant to M.G.L. c. 30A. If after the hearing, the Commissioner determines that the utilization review agent has violated or is in violation of these regulations, the Commissioner shall issue an order requiring the insurer and/or utilization review agent to cease and desist from engaging in the violations. The Commissioner may also suspend or revoke his approval of the utilization review agent's ability to conduct utilization review.	

V	REVIEWER CREDENTIALING PROCESS	YES	NO	INC	Regulatory Requirements	Reviewer Comments/Recommendations/ Suggestions
A.	**Exhibit I1:** **Provide a *detailed description* in narrative form of the applicant's credentialing and verification process for it's medical director or clinical director, school to school reviewers, registered nurses, and all other clinical reviewers. Include the following:** 1. Credentialing criteria for all clinical review personnel. 2. Credentialing procedures that ensure that all clinical review staff are properly qualified and credentialed to provide a clinical opinion about the health care service under review. 3. Procedures to ensure that all-clinical review staff hold a current unrestricted license to practice. 4. Clinical review staff are properly qualified and credentialed to provide a clinical opinion about the health care service(s) under review. 5. Are the credentials of all level reviewers verified, what is the process for doing so. 6. Verification that all clinical reviewers are in active practice 8 hours per week. 7. Copies of job descriptions for each reviewer title involved in the initial clinical review and appeal level school-to-school review. Job descriptions must be submitted for each different position title involved in the clinical review process. 8. Job descriptions of employees performing non-licensed administrative functions for the utilization review department. 9. Job description for the medical/clinical director who provides medical support to clinical reviewers. Medical Director job description includes licensure and Board Certification.				Program shall ensure that reviewers are licensed and in good standing to practice in their respective states.	
B.	**Exhibit I2:** **Describe the initial and on-going processes for credentialing & verification of credentials of the applicant's sub-contracted reviewers.** 1. If credentialing process is sub-contracted the Program has policies and procedures in place to monitor the subcontractor's performance and compliance with the Program's stated compliance policy. 2. The policy also indicates how the Program completes periodic review of the subcontractor's policies and procedures. Including periodic verification of credentials. 3. Include policies and a procedure for credentialing process that describes who is responsible for this process, how is it completed, what are the requirements, and what is the procedure. 4. The UR organization has a policy that requires school to school reviewer to be providing patient care at least 8 hours per week in accordance with 452 CMR 6.00 et seq. How does the sub contractor provide for this requirement and how does the UR agent monitor.				If the Program sub-contracts' any part of their credentialing or re-credentialing process it must have in place policies and procedures that verify that the program provides appropriate oversight of the subcontracted function(s)	

VI	TELEPHONE SYSTEM	YES	NO	INC	Regulatory Requirements	Reviewer Comments/Recommendations/ Suggestions
A.	**Exhibit J1** **Indicate the days and hours (EST) of operation during which the applicant's reviewers will be available to perform Utilization Review.** 1. The UR organization has written procedures that indicate access to its clinical review staff by a toll-free telephone line at a minimum of 9am to 5pm of each normal business day in each time zone where the program conducts utilization review.					
	Exhibit J2: **The UR organization has written procedures that describe the organization's system for receipt of telephone calls and messages during non-business hours which:** 1. Includes procedures for receiving or redirecting after hour's calls. 2. Includes procedure that indicates how soon calls are returned.				The telephone systems of the Program must be capable of accepting or recording incoming calls during non-business hours. The system must be a confidential line within the UR department. How are the messages kept confidential. Each Program must declare in its program application how soon following the receipt of a telephone call a return call will take place.	
	Exhibit K: **Indicate whether the applicant will utilize toll-free telephone script(s), automated call distribution greetings, recorded messages, and/or live script(s) specific to the Program.** 1. Include description of message scripts and processes.					

VII	GENERAL REQUIREMENTS: Exhibit L	YES	NO	INC	Regulatory Requirements	Reviewer Comments/Recommendations/Suggestions
A.	**Does the applicant have written policies and procedures for assuring the confidentiality of patient specific information obtained during the Utilization Review process?**					
B.	**Does the applicant have professional and general liability coverage, at limits of not less than one million dollars per occurrences?**					
	Exhibit M: **The UR organization has a written procedure that includes a list all insurers with whom the UR organization will contract with and a description of the contractual agreement(s) for utilization review services.**					
	Exhibit N: **The UR organization provides a list all entities with which the organization will sub-contract for the provision of some portion(s) of the organization's UR program.** 1. The UR organization has written procedures for the monitoring of all sub-contractors' performance with the organization and compliance with 452 CMR 6.0.					
	Terms and definitions throughout the application and in all exhibits accurately reflect and paraphrase the provisions of 452 CMR 6.00 et seq.				Applicants are required to be familiar with the content of 452 CMR 6.00 et seq.	
	Application endorses and reflects through out that the only utilization review criteria which will be applied first relative to medical conditions are those published by this department.					
VIII	**Application is signed by authorized representative certifying that they have read and understands 452 CMR 6.00 et seq. and shall comply with all applicable Massachusetts and Federal Laws including, but not limited to, those laws which protect the confidentiality of medical records. In addition the signature certifies that all other information provided with this application is neither falsified nor fraudulent.**					
I.	**Additional Comments:**					
	8/2/05					

Definitions

For the purpose of completing this application, the following application terms used must be consistent with 452 CMR 6.00 et seq. The following definitions must be used for approval.

1. **Injured employee:** The person who files a claim for benefits.
2. **Clinical Director:** A health care professional who is duly licensed to practice in at least one state in the United States and has the responsibility for clinical oversight and management of the Program's utilization management functions.
3. **Approval Determination:** A approval determination by the Program that indicates that based on the information provided, the health care service(s) being reviewed meets the clinical requirements for medical necessity, appropriateness, under the auspices of the HCSB Treatment Guidelines and Review Criteria or secondary review criteria used.
4. **Health Care Services Board Treatment Guidelines and Review Criteria (HCSB):** The written protocols to determine medical necessity and appropriateness of medical care. Programs shall consider the HCSB treatment guidelines endorsed by the Health Care services Board and adopted by the Commissioner when caring for injured employees. The adopted guidelines shall be used by utilization reviewed programs administered by insurers in a form required by the Department, taking into account that appropriate care may vary on a case by case basis.

5. **Utilization Review:** Evaluation of the medical necessity and appropriateness of health services under the auspices of the Health Care Services Board and Department of Industrial Accidents.
6. **Ordering Provider/Practitioner:** The physician or health care providers who specifically prescribe(s) the heath care service(s) being reviewed.
7. **Medical Director:** A doctor of medicine or doctor of osteopathy which is duly licensed to practice in at least one state in the United States and has the responsibility for the clinical oversight of the utilization management program functions.
8. **Clinical Reviewer:** A licensed physician or other licensed health care professional who holds a non-restricted license in a state of the United States.
9. **School-to-School Reviewer:** A licensed physician or other health care professional who is defined by their professional degree. Schools include but are not limited to, physical and occupational therapy, osteopathic allopathic, nursing and dentistry.
10. **Prospective Review:** Utilization review conducted prior to a patient's health care services or course of treatment (including, but not limited to, outpatient procedures, office visits, durable medical equipment and some pharmaceuticals). May also include services for which care has been initiated prior to the request for prospective review that will:
    1) Continue prospectively such as a PT evaluation prior to the request for prospective review of condition/diagnosis requiring physical therapy, and;
    2) The same treatment provider and;
    3) The same condition/diagnosis and ICD-9 code.
    Notice of determination must occur within two business days of the receipt of request for determination and the receipt of all information necessary to complete the review
11. **Concurrent Review: A** review of ongoing care. For concurrent review, the notification should be within one day prior to implementation i.e. discharge.
12. **Retrospective Review:** A medical record review of treatment that has already been rendered. For retrospective review, the notification should be within 10 days of the adverse determination.
13. **Adverse Determination:** An adverse determination is a denial of the appropriateness or necessity of a health care service. Any adverse determination by a UR agent as to a health care service must include a detailed description of the services rendered, as required by G.L. c. 152, section 13, and must be reviewed by a licensed practitioner. When the service is ordered by a practitioner, a practitioner in the same school as the ordering practitioner must conduct the review. An important part of the UR program is the requirement that when a UR agent issues an adverse determination, the agent must notify both the worker and the treating provider in writing and:
    - provide the guideline used to review the treatment;
    - identify the reasons why the proposed treatment failed to meet the appropriate applicable guideline; and
    - inform the injured worker and the ordering provider of the right to appeal the UR determination.
14. **Expedited Appeal:** When an adverse determination not to approve a health care service is prior to, or during, an ongoing service requiring review, and the injured employee, and/or the ordering provider believes that determination warrants immediate appeal, the injured employee and/or ordering provider shall have an opportunity to appeal that determination over the telephone to the UR agent, with the right to speak to a practitioner of the same school as the ordering provider on an expedited basis. The appeal must occur no later than 30 days from the date of the receipt of notice of adverse determination. UR agents shall complete the adjudication on an expedited basis, but at least within two business days of the date the appeal is made.
15. **Standard Appeal:** Adjudication of all other appeals of adverse determinations must be completed within twenty days from the date the appeal is filed.